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Borderlands Curanderismo:

Folk Healing in the Rio Grande Valley

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Borderlands Curanderismo:

Folk Healing in the Rio Grande Valley

by

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Dedication

To my parents, who have given me unconditional love and support.

To my grandmother, whose profound knowledge inspired me to pursue this project.

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Abstract

Borderlands Curanderismo:

Folk Healing in the Rio Grande Valley

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The University of Texas at Austin, 2016

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This study examines the ways the Rio Grande Valley of South Texas has been a unique haven for the Mexican and Mexican American folk healing system of *curanderismo*, as well as other informal approaches to healthcare. I argue that this trend in inherently connected to the emergence of Tejano identity in the Rio Grande Valley, which has deep connections to notions of sovereignty and self-sufficiency in the borderlands. My research provides a brief history of the South Texas region and the formation of Tejano identity. This identity formation is considered in relation to the multiple modes of traditional and informal healthcare practices continuously practiced in the region, despite the region's recent surge in medical development. Further, it suggests contemporary models for community engagement and graduate medical education that, if implemented, could serve the Rio Grande Valley's population (which is currently over 90% Latino) in innovative ways. Most importantly, this M.A. report exposes aspects of the region's historically insufficient healthcare systems based upon one local woman's oral history.

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Introduction

On December 6, 2012, The University of Texas System Board of Regents announced plans to consolidate the University of Texas Pan American and the University of Texas at Brownsville into a single South Texas university. Now called the University of Texas Rio Grande Valley, (UT-RGV), the institution will establish the region's first medical school.[1] The UT-RGV School of Medicine will open in the fall of 2016 with an inaugural class of 50 first-year medical students, and is described on the school's website as a "journey that will transform the region, state and the nation by becoming a leader in student success, teaching, research and healthcare," connecting "science with the communities."[2] The medical school will undoubtedly revolutionize healthcare in the historically underserved region of the Rio Grande Valley, where access to biomedical institutions has been historically limited due to the region's geographic distance from U.S. urban centers, and furthered by its large uninsured and impoverished Mexican and Tejano population.[3] However, I argue that the medical school and their well-funded public health campaigns will do little to acknowledge or address the structural issues that currently face the underserved low income communities of the Rio Grande Valley, and that result in a regional reliance on folk healing or other informal healthcare practices. Like most U.S. biomedical institutions, their medical professionals – who will be required to complete their residency in the Rio Grande Valley – will be trained primarily to perceive their patients as individual bodies to be treated, and not as part of specific communities in particular social, historical, political, and economic circumstances that directly affect their health.

This M.A. report focuses on the ways the Rio Grande Valley has historically been a unique haven for the Mexican and Mexican American folk healing system of *curanderismo* and other informal approaches to healthcare and the ways this trend is inherently connected to the emergence and continuous presence of Tejano identity in the Rio Grande Valley (referred to from here onward as simply the valley or the RGV). A thorough discussion of healthcare in the RGV is not only vital to understanding the region's current economic development, but to understanding the region's identity and struggles for survival in a harsh environment, where for centuries its poorer inhabitants have been forced to rely on self-sufficient, herbal, and traditional community-based modes of holistic healing. My research first offers a history of the region and the identity formation of its inhabitants, and then discusses multiple modes of informal and traditional healing in the region. Secondly, it suggests contemporary models for research and graduate medical education that, if implemented, could serve the RGV's specific healthcare needs in innovative ways. Lastly, and most importantly, this M.A. report exposes aspects of the region's historically insufficient healthcare systems based upon one local woman's oral history. While one example, Elva Guzman's history reveals the ways that the region's inhabitants have often been at odds with the biomedical system and have taken healthcare into their own hands, relying on community medical knowledge, local resources, and *curanderas/os* (traditional folk healers) to survive.

My approach integrates primary sources, media, scholarly and archival sources, and recent healthcare statistics and sources to outline a cultural and historical record of the region. Further, its methodological incorporation of one woman's oral history

contributes to a process that Monica Muñoz Martinez calls "vernacular history-making" – a process of "bringing into the public sphere alternative histories that were previously shared only in private spaces among trusted friends and family."[4] Together, these approaches place the RGV's complex history in conversation with its current healthcare needs and recommends sustainable education and healthcare measures that take into account the vitality of the region's culture, its structural positionality, and its people's understanding of the self, the body, and sustainable community healthcare.

Curanderismo is a centuries-old folk healing system with complex roots steeped in the Arabic, Spanish, Judeo-Christian, and Native American tradition, popular in many Mexican and Mexican American communities.[5] Its practices range from herbal remedies to massage, prayer, spiritual cleansing, midwifery, bone setting, and, in some cases, witchcraft and magic. Typically, the Rio Grande Valley's biomedical institutions have not acknowledged – much less accepted – the practice of *curanderismo* in the region, and in many cases have even scorned its use. Lower and working-class Tejano communities in the RGV especially regard *curanderismo* and other informal health care practices, such as crossing the border for medications and medical care, as central components of the region's history, health, and traditions in the face of public resource depravation. These same lower and working-class Tejanos are said to be the target service populations for the UT-RGV School of Medicine's community-based medical outreach and service programs.[6] Drawing from Elva Guzman's oral history and her understanding of *curanderismo* and its healers, I delineate community-centered understandings of *curanderismo's* cultural and historical meanings in the region, and the ways these

histories should dictate the upcoming medical school's culturally and structurally competent interaction with the community.

While Elva did not name competency as something the medical system was lacking, it nonetheless is a central component for implementing relevant medical and social services. Cultural Competency in medical school education is a fairly new concept that raises the standards in medical education, prioritizing healthcare disparity reduction and the promotion of cultural and regional understandings of sustainable healthcare practices where residents work. Structural competency – which was created in hopes of filling some of the gaps created by cultural competency – consists of training healthcare professionals to perceive of health inequalities and patients "in relation to the institutions and social conditions that determine [their] health related resources,"[7] and to "recognize the complexity of the structural constraints that patients and doctors operate within."[8] There is tremendous potential in the incorporation of cultural and structural competency models in the RGV, its medical school, and public health campaigns, based on the region's unique history, healthcare needs, and a regional identity that requires deeper understandings of the community's values and structural inequalities.

Discussing regional identity formation and historical understandings of health and healthcare in the RGV enables an awareness of alternative models of healing and sustainable healthcare in a variety of contexts – traditional, informal, and biomedical. Similar to McKiernan-González and his investigation of race and public health along the border, I am interested in the ways public health "provide[s] a rich staging for encounters between medical professionals, political authorities, and working-class residents; for

processes that expose the interplay of local and national identities; and for the forging of ethnic identities at places where two nations staged and built their own changing identities."[9] Thus, my project delineates the unique aspects of health and healthcare in the South Texas landscape from varying vantage points and advocates for formal recognition of the region's structural positionality within mainstream models of healthcare. In the following section, I discuss the development of a regional Tejano identity in a borderlands environment distant from the economic centers of both the U.S. and Mexico to set up the healthcare conversation. I argue that this history and identity formation is central to the preservation and continuation of traditional healthcare practices and directly relates to the way the region and its inhabitants envision their relationship to mainstream healthcare institutions.

Tejano Identity

According to the 2010 U.S. Census, of the over 50 million people that marked "Hispanic/Latino" as their ethnicity, 5.87% of them self-described as "Other Hispanic/Latino," coded by the Census Bureau as any of the following self-descriptions: Latin American, Latin, Latino, Hispanic, *Tejano, Californio, Nuevo Mexicano*, Spanish American Indian, Meso American Indian, and Mestizo (emphasis mine).[10] While the census records I found do not publish the exact numerical breakdown of the categories in the nearly 3 million "Other Hispanic/Latino" respondents, the classification enabled me to think critically about my own understandings and misunderstandings of Tejano identity – an identity popularly claimed in the RGV.[11] What were the factors that led to the unique formation of a state-based ethnic identification? Further, and most importantly, how can the ambiguous and contested ethnic label, "Tejano," inform and complicate our understandings of race, ethnicity, and class in the RGV, enabling a more nuanced awareness of identity in relation to the region's healthcare needs?

By beginning here, I reiterate both the importance and ambiguity of classification systems regarding race and ethnicity in the United States, providing a framework for the following discussion of a very specific group of U.S. Latinos – "Tejanos." In doing so, we can consider why Tejano matters and how it contributes to both emerging Latina/o Studies and healthcare discourses concerning the ways insider and outsider labels affect not only identity formation, but also self-defined claims for political inclusion and belonging in a hybrid borderlands culture inclusive of Mexican, Mexican American, Anglo-American, and Indigenous knowledges. Tejano is an excellent entryway into

analyzing these larger issues, particularly because unlike the term "Hispanic," the U.S. government or Census did not create it. I argue that Tejano is a product of Mexican-American self-definition and an in-group understanding that is inherently related to historical, cultural, and geographical ties to the state of Texas.

Suzanne Oboler, in *Ethnic Labels, Latino Lives: Identity and the Politics of (Re)Presentation in the United States,* provides an analysis of the term "Hispanic" in the United States, exploring its emergence in the 1970s and the ways it has become a contentious pan-Latino ethnic label because it overlooks the diversity and history of Latino groups in the United States. She claims, "while the homogenizing nature of ethnic labels is perhaps inevitable, the lack of historical memory that often accompanies their use means that there is often very little understanding of the conditions under which each label was created and through which its meanings and social value have been shaped and changed over time."[12] This change over time is crucial since, particularly in the United States – a nation built on colonization, immigration, and slavery – labels based on race and ethnicity have consistently been crucial to defining and limiting people's claim to rights, citizenship, and power. Ethnic labels have shifted, particularly after the civil rights movement, when organized efforts were made to combat discrimination and embrace ethnic cultural preservation in the United States. Considering such shifts and alliances, Oboler also discusses the emergent possibilities inherent in pan-Latino ethnic terms and the ways they can enable a much-needed U.S.-Latino solidarity that transcends national origins. Her work emphasizes the need to better understand and deconstruct ethnic labels because with them, we can uncover ethnic histories and their resulting personal, legal,

social, and political meanings in the ever-changing racial and ethnic climate of the U.S. Borrowing from Oboler's work, my close analysis of the ethnic label, Tejano, yokes this subject position to health, regional difference, and the continuously contested positionality and citizenship of Mexican Americans in the U.S.-Mexico borderlands.

Legal and political historian, Mae Ngai, discusses the ways that "the need of state authorities to identify and distinguish between citizens…[often poses] enforcement, political and constitutional problems for the modern state."[13] Her work offers a thorough and necessary understanding of the shifting legal definitions and notions of citizenship concerning the U.S.-Mexico border, race, and illegality, arguing that their historical, social, and legal constructions are consistently malleable and dependent on "Americans' understanding of national membership and citizenship, [which draws] lines of inclusion and exclusion that articulate a desired composition – imagined if not necessarily realized – of the nation."[14] Ngai explores legal processes of racialization and "becoming," discussing the shifting legal definitions of ethnic groups who have not fit the black white binary, and thus, become "alien citizens…[who despite being] born in the United States with formal U.S. citizenship, remain alien in the eyes of the nation"[15]

These racial formations and label-based exclusions in the United States undoubtedly influence understandings of identity and community, particularly when a population has a strong presence in a geographical area. Historian George J. Sánchez, for example, in his discussion of Mexican immigrant communities in Los Angeles, argues that over time they "acclimated themselves to life north of the border, [and] did not remain Mexicans simply living in the United States, they *became Mexican Americans*.

They assumed a new ethnic identity, a cultural orientation which accepted the possibilities of a future in their new land" (emphasis mine).[16] For Sánchez, these possibilities included the formation of community and political organizations that allowed for Mexican Americans to retain their culture and combat racism. My analysis of Tejano draws largely from Ngai's and Sánchez' exploration of identity, community, and citizenship. However, Tejano cannot be understood without a brief discussion of conquest and colonialism in Texas, and the ways scholars of Tejano history have painted ambiguous and malleable understandings of the referent describing completely different Mexican-American groups living in Texas and their culture.

Omar Valerio-Jiménez, in *River of Hope: Forging Identity and Nation in the Rio Grande Borderlands* (2013), provides a historical analysis of the emergence of Texas-Mexican identity in relation to the state's complex colonial history under France (1684-1689), Spain (1690-1821), Mexico (1821-1836), the independent Republic of Texas (1836-1845), and finally as an annexed state in the U.S. (1845-present). He locates the formation of Texas-Mexican identity in the South Texas borderlands, describing the ways the zone "[was] once located on the periphery of European colonial power and subsequently on a newly created international border" – further, he discusses the ways the region's history is "a story of violence resulting from multiple conquests, of resistance and accommodation to state power, and of changing ethnic and political identities."[17] Under Spain for over a century, what is now Texas was composed of a harsh racial and class-based hierarchy with Spanish colonists and their land-owning descendants at the top, mestizos in the middle-lower strata, and the indigenous populations at the bottom,

often as part of the *criado* servant/slave class or as antagonistic yet independent nomadic tribes. The remnants of this racial and class hierarchy remained long after Mexico gained its independence from Spain in 1821, and were still in place socially while the South Texas borderlands were part of Mexico until 1836. These deeply rooted social structures based on class and racialization continued while the borderlands became a disputed zone of the Independent Republic of Texas, persisting even after Texas annexation in 1845. However, after 1845, as more Anglo-Americans moved into Texas and its contested borderlands, Texas-Mexicans of every caste lost political and economic power as they became racialized and subordinate members of American society.[18] This subordination and marginalization is crucial to understanding Tejano institutional distrust.

Although the Treaty of Guadalupe Hidalgo (1848) guaranteed that the Spanish and Mexican inhabitants of the annexed lands of the Southwest would be legally considered white American citizens, "the rights guaranteed… – ownership of the land, due process of law, maintenance of the culture, and others – were quickly undermined by the Anglo community."[19] The acceptance or exclusion of Mexican Americans in American society after 1848 became entirely dependent on racialization, ethnic labels, and classification systems. This shift, which occurred through violent, discriminatory contact with Anglo-American settlers, is usually where scholars have placed the emergence of Texas-Mexican, often and interchangeably called, Tejano identity.

Throughout the 1980s and 1990s, Mexican-American scholars published some of the first histories on Tejanos or Texas-Mexicans, emphasizing the ways that these Mexicans underwent a process of Mexican-American biculturation and ethnic identity

formation.[20] In these early manifestations of scholarship about Tejanos, the term's emergence and definition as an ethnic label remains ambiguous when it comes to distinguishing which racial and class groups are included and excluded from its usage. The word generally references any person of Mexican-descent living in Texas and usually does not demarcate differences in class, race, power, and culture. These scholars frequently allude to Tejano identity as emerging from the landowning descendants of Spanish and elite Mexican settlers, often skirting around the issues of violence and divisiveness among Texas-Mexicans and their oppression of Indigenous and black populations. I maintain that these obscure and conflicting understandings of Tejano identity emergence and definition are intrinsically tied to Texas' complex colonial history that muddles the ability to clearly define a people who – particularly in the first half of the nineteenth century – fell under different state powers every few decades. Further, it is increasingly difficult to distinguish between these groups, given that Mexican identity is rooted in the idea of mestizaje and that over time, intermarriage and biculturation increasingly became the norm in South Texas.

In a unique analysis of the South Texas borderlands and its people, David Arreola contends, "*Tejano South Texas* is a cis-Rio Grande cultural province [that] is geographically defined by its position on the U.S. side of the Rio Grande, although its cultural heritage is linked to Mexico" (emphasis mine).[21] His understanding of Tejano far overreaches previous interpretations, as he applies it as an adjective to describe the entire southern borderland regions of Texas. Later, Raúl Alberto Ramos, in *Beyond the Alamo,* argues that Tejano is a local and regional identity. He often distinguishes between elite

Tejanos and poorer Tejanos, staking a claim in their solidarity through the ways they "developed a unique borderlands identity that shifted from the isolated character of the late colonial period to the border condition of the early national period."[22] Ramos understands Tejano identity as "proto-national," "[emphasizing] elements of nationalism beyond those officially defined by the state or that describe a single identity."[23] One of his most unique scholarly contributions is his discussion of indigeneity, where he opens up the possibility for people to "become Tejano" through intermarriage and intergenerational ties to the land, noting that "perhaps the loss of context and nuance of the indigenous elements of Tejano identity lies in the radical restructuring of identities resulting from American expansion into Texas."[24] Further, he addresses the large and persistent gaps in his analysis and the historical barriers that today limit the preservation and availability of indigenous Tejano perspectives, as well as those of ordinary non-elite Tejanos.[25]

Scholars have continued to interpret Tejano through similar narratives of inclusion. Combating exclusionary and elitist notions of Tejano as only those upper-class descendants of colonists, Valerio-Jiménez disentangles some of the ways Anglo-Americans perceived certain elite Tejanos as white and assimilable citizens in contrast to poor darker-skinned Tejanos. He links "this class-based racialization" to Historian Matthew Frye Jacobson's argument "that culture and politics rather than nature define race," describing the complex ways "the instability of race arises from [the] cultural and political dynamics that alter which groups can claim the privileges of whiteness."[26]

In making sense of the scholarship on Tejanos, I have formulated my own definition of the term, which is in line with several discussions on ethnic labeling, identity formation, and understandings of Tejano as a hybrid identity. Yet, it diverges to expand on questions of racial and class-based solidarity. My expansive understanding of Tejanos and their cultures is inclusive of both the colonial descendants of Spanish settlers, the indigenous or mestizo lower classes of the same time period, and the more recent Mexican immigrants who have connected to the Texas-Mexican culture of the borderlands through multiple generations. Contrary to those who have associated the term with the land-owning, Spanish-descended lighter-skinned Tejanos who have remained in South Texas for centuries, I understand the term as an ethnic label that has emergent possibilities for geographic and spatial solidarity. As an ethnic label, it can empower and build solidarity based on an affiliation with borderlands cultures and ethnicities, the state's multicultural identity, food, music, and its constant contact and exchange with newer Mexican migrant streams.[27] Tejano complicates restricted understandings of race and ethnicity and can be applied to people of Mexican descent that were either born in Texas or have resided there long enough to feel connected to the Texas-Mexican culture of the borderlands.

I interpret its formation and usage as first emerging from Mexican independence from Spain in 1821 and the subsequent decades of various nation-building clashes in South Texas. The turning point and solidification came with the formation of the Independent Republic of Texas in 1836 and the later annexation of Texas in 1845, resulting in a shared regional Texas-Mexican experience in the borderlands – reiterating

what Mae Ngai calls "alien citizenship" – pervasive marginalization from American understandings of nationhood, regardless of formal American citizenship.[28] Unlike Hispanic or Latino, Tejano's importance as an ethnic label and identity lies in its roots as a specific regional self-referent that claims a pervasive and historical Mexican presence in Texas. While there are multifaceted experiences in this ethnic identity that emerge from relationships to privilege and generational connections to the region, the term's unifying potential can acknowledge harsh and divisive notions of race and class in order to transcend them and build solidarity among a diverse people who share complex and layered histories of migration, colonization, violence, and cultural retention in their border homelands.

The scholars mentioned previously have located Tejano in South Texas, with very few deconstructing the etymology of the word, the conditions of its creation, and its ever-changing definitions in relation to identity formation and the racialization of particular racially-marked Tejano groups. Principal to the pervasiveness of this gap is the reality that very few of them have been able to include the views, culture, and identity of the common, ordinary folks below. The difficulty in arriving to these narratives lies in "the significant barriers [that] hinder the task of completely reconstructing nineteenth century Tejano identity."[29] Ramos describes how rarely "documents surface that clearly state [the] beliefs [of ordinary Tejanos] or [their] ideas regarding identity."[30] Thus, the only way for scholars to address these gaps is to seek out, collect, and engage with primary sources outside of the archives and historical records, where marginal Tejano and Tejana voices will not be found. Recovering this history, particularly along the U.S.-Mexico

border, is a task that is not always simple, given that the "U.S.-Mexico borderlands 'is not a space of absolutes'…. It is a region where native populations… engage in daily practices that blur the neat national boundaries found on maps."[31]

My work enters these messy unbound zones and contributes to such historical discourses through the lenses of healthcare and identity. The scholarly perspectives here, including my own, remember not only the racial and ethnic horrors of our nation's history, but also reveal the agency, adaptation, and self-definition consistently exhibited by Mexican Americans in the United States borderlands. Analysis of identity formation is crucial to a larger understanding of the RGV, its people, and its relationship to health and biomedical institutions, as it reveals a long history of the region's hybridity, marginalization from both the U.S and Mexico's resources, and a self-sufficient reliance on the land, while remaining inclusive of the often forgotten or willfully ignored indigenous knowledges and perceptions of health and spirituality in the RGV. Tejano identity, as alien citizenship and a presence in a particular geographical time and place, encompasses traditional healing methods and informal healthcare practices. Folk healing and self-sufficiency is an important subset of this Tejano regional identity and culture.

Healthcare in the Lower Rio Grande Valley of South Texas

The history of healthcare and biomedical development in the RGV is important to the region's specific and contemporary healthcare practices and disparities. Addressing these issues and contradictions will paint a clearer picture of the region's needs and enable a consideration of approaches and solutions that may serve the community and its institutions in a more culturally and structurally competent, sensitive, and regionally-tailored manner. Several factors in the RGV lead to a common reliance – or at the least, familiarity – with a multitude of informal healthcare practices outside of mainstream biomedical institutions and understandings of illness, particularly since 90% of the region's population is Latino – the majority of which are Mexican, Mexican American, or Tejano. If most valley residents have not visited a *curandera/o* for physical or spiritual health care services, they know someone who has, and can easily narrate stories of miracles or disasters associated with the experience. It is not uncommon for someone in the valley to touch a young child or object they find attractive because of his or her belief in the power of *mal de ojo* (evil eye), a folk illness caused by a strong gaze of admiration or envy that can cause immediate harm to a person or object if the negative energy is not released through prayer or touch. It would not be surprising for friends and family members in the RGV to recommend herbal or household remedies for small ailments and discomforts, or for a friend to suggest crossing the border into Reynosa or Nuevo Progreso to purchase prescription drugs or dental care for a fraction of the cost commonly charged in the valley's clinics and hospitals. Chad Richardson argues that three regional

factors directly affect these phenomena: low income, low rates of medical insurance coverage, and high costs of medical care.[32]

In 2014, the state of Texas had the highest uninsured population in the United States, with a whopping 19.1% of its residents lacking medical insurance coverage.[33] In 2015, the Lower Rio Grande Valley was specifically ranked among both the state and the nation's least insured regions, with 30% of Cameron County, 33% of Hidalgo County, and 34% of Starr County's population without medical insurance.[34] Additionally, most counties in the lower RGV have nearly twice the state average of their residents living below the poverty line, with a per capita income of less than $15,000, as well as a higher average number of persons per household.[35] These three predominantly Mexican-American counties reside along the U.S.-Mexico border, have high levels of poverty, low levels of education, and large migrant communities. With such large disparities and a regional lack of access and affordability, one would think that the region's healthcare institutions would be suffering. However, quite the opposite is true. The RGV is currently home to some of the United States' fastest-growing hospitals and boasts one of the nation's fastest-growing populations and strongest economies.[36] McAllen, Texas, the center of healthcare development in the RGV, is "the most expensive town in the most expensive country for healthcare in the world," which journalist Atul Gawande attributes to the overuse of medicine in the RGV and the ways the region's medical community has come "to treat patients the way subprime-mortgage lenders treated home buyers: as profit centers."[37] These factors, which weigh heavily on the region's healthcare disparities and do little to address larger structural issues of migration, poverty, lack of education, and a

lack of long-term health care compliance. This has resulted in the RGV being described as a region in "epidemiological transition," "a condition in which areas of the developed nations begin to acquire some of the health problems of developing countries."[38] Some of the most pressing health problems in the RGV include higher than national average rates of tuberculosis, sexually transmitted infections, HPV, obesity, and diabetes.[39]

In 2000, Mexico and the U.S. made strides at addressing the severe health disparities along the border, creating the binational health commission and public international organization, The United States-Mexico Border Health Commission (BHC), whose mission it is to "provide international leadership to optimize health and quality of life along the U.S.-Mexico border."[40] Six strategic priorities of the BHC include (1) access to care, (2) strategic planning, (3) research, data collection, and academic alliances, (4) tuberculosis, (5) obesity and diabetes, (6) infectious disease and public health emergencies.[41] While this commission and several other community outreach programs like it have engaged with the RGV's poorer communities and their immediate healthcare needs, most have served as a temporary cure for a larger systemic problem: the ways in which the majority of borderlands residents do not benefit from the economic development of their regions, consistently live in severe poverty among subpar infrastructure relative to the rest of the nation, and are forced to survive and make do with extremely unaffordable and overcrowded biomedical institutions, which often take advantage of public services by ordering large amounts of unnecessary testing, treatments, and care.[42] Thus, large segments of the RGV's population, both insured and

uninsured, seek out alternative methods of healthcare and education to either supplement non-existent care or replace costly and often ineffective biomedical treatment.

One particularly dramatic and relevant example of such alternative methods includes the ways RGV women have come together as support systems and community educators to combat the lack of women's health and family planning resources in the region. In response to Texas legislature policies of 2011, which severely cut funding to women's health and reproductive services throughout the state, and critically affected the low-cost clinics of the RGV, a human rights campaign going by the name of "Nuestro Texas: Comunidad, Salud, y Familia" was formed to address regional disparities.[43] In 2012, one of its investigations outlined barriers RGV women have historically faced in attempting to access basic reproductive health care, including but not limited to: accessible clinics, cost, transportation, and immigration status.[44] Recent policies that severed funding for several of the region's women's health clinics such as Planned Parenthood, have only exasperated problems of access and affordability, causing increases in unintended pregnancies, sexually transmitted infections, and reproductive system cancers that are otherwise preventable and treatable.[45] Nuestro Texas is an example of the ways the RGV's needs and the health of its people have been forgotten by the state of Texas and its conservative political and economic policies. Women in the RGV are not receiving even the most basic forms of support from the state, instead choosing to partner with outside agencies such as the National Latina Institute for Reproductive Health (NLIRH) and the Center for Reproductive Rights, to advocate at the

state, national, and international level for reproductive healthcare for all women, formulating their most recent regional issues as human rights abuses.

Even with community support systems and educational outreach, several of the region's community health workers (*promotoras*) decry the ways their health education in many instances has become futile, since ill and distraught community members often become educated on their illnesses and the ways to prevent and treat it, yet have nowhere to turn for accessible and affordable resources and treatment.[46] Some of these community health workers have lost faith in the U.S. medical system and its health resources, often advising community members to seek out informal methods of healthcare, such as crossing the border into Mexico to receive more affordable care or prescription medications, which can easily be bought over the counter in Mexican pharmacies. Thus, to acquire healthcare informally, many RGV residents make the risky trip to the Mexican state of Tamaulipas, which borders the lower RGV and currently has a critical crime rating by the U.S. Department of State, as well as the highest rate of kidnapping in all of Mexico.[47] This kind of medical tourism demonstrates the RGV's geographic, economic, and physical reliance on the resources of its neighbor to the south, and is important in considering the self-sufficient ways U.S. citizens in the RGV borderlands have come to envision their healthcare options in a state and nation that has systemically excluded them from access to the basic human rights of life and health.

For other RGV residents who are not U.S. citizens, the issue becomes even more complex and difficult. It is estimated that around one third of the valley's population currently works in the agricultural sector.[48] The large majority of those laborers are

undocumented migrants who often face health and healthcare issues further complicated by their immigration and labor status. Migrant workers endure enormous physical demands daily and often have poor living conditions because of their reliance on temporary housing in migrant camps or colonias – sites with shoddy infrastructure and little to no access to water and sanitation. Tuberculosis, often related to poor living conditions, has a high prevalence among migrant workers – six times higher than the national average.[49] HIV infection is also three times more prevalent in these communities than the national average.[50] For undocumented migrant workers in the RGV who cannot cross the border into Mexico for affordable treatment due to their inability to return to their jobs and families in the U.S., their health issues are often quietly endured or ignored unless they happen to be offered affordable treatment through some of the few organizations that do not require state identification and co-pays, such as mobile clinics or community outreach programs such as the Migrant Clinicians Network.

The Valley's first medical school is undoubtedly a turning point in the region's history, but it will not be a productive one if it rushes in abrasively, ignoring the region's values and traditions and refusing to address the long-standing distrust that many locals have of the biomedical system because of their perpetual marginalization from it. Oftentimes medical professionals discuss certain populations and their unwillingness to comply with medical advice as problematic and reflective of stubborn individuals who do not want to be helped. While this certainly may be the case in particular instances, distrust of the biomedical system and alienation from accessible care in the RGV is inherently tied to its location along the Texas-Mexico border and the region's history of

self-sufficiency and suspicion of authority. John McKiernan González' recent work demonstrates the deep-rooted history of medical distrust and ethnic public health conflict along the Texas-Mexican border. He argues, "imperial incorporation and ethnic subordination through public health measures predated the creation of the Mexican Republic and the American-Mexican border," and that "public health matters at the Texas-Mexico border [have been] as much a question of national belonging as of medical authority."[51]

This history in the face of disparity, institutional, regional, and ethnic marginalization is necessary to understanding the region's current needs. Until the early 1900s, the RGV was an undeveloped rural area predominantly used for ranching and farming, with small populations living in isolated communities fairly distanced from the advanced medical resources available in larger Texan and Mexican cities.[52] In Trotter and Chavira's *Curanderismo,* they describe difficulties RGV residents have historically faced in accessing healthcare at the turn of the century because few medical professionals were willing to live in an area with immense distances between populations, lack of resources, and improper medical facilities.[53] This isolated environment forced people to rely either on Anglo and often racist doctors who came to town with federal military programs and public health campaigns, or on community medical knowledge and spiritual and holistic guidance provided by *curanderas/os.* Their geographic limitations warranted a healing system based on natural resources available in the immediate environment, as well as a cultural understanding of the religious and cultural practices and belief systems of Mexicans and Tejanos in the area.

Over time, the development of irrigation networks, roads, and railroads slowly encouraged new residents, medical professionals, and mineral and agricultural industries to flourish in the RGV. However, these developments in no way diminished the presence of *curanderismo* in the area, since several inequalities and cultural barriers worked together to deny Mexicans and Mexican Americans in the RGV equal access to the modern biomedical system, particularly among the racially marked lower classes.[54] In fact, although the first few hospitals in the RGV opened their doors in 1913, 1917, and 1919 in Brownsville, Harlingen, and McAllen, respectively, their main focus at the time was the treatment of wartime injuries from the Mexican Revolution, which brought countless injured soldiers and civilians across the border into Brownsville and its neighboring communities.[55] While the Mexican Revolution brought several Mexican immigrants to the RGV and spurred the region's medical development, racial and economic inequalities persisted, as they do today, distancing certain populations from affordable healthcare resources and education. Traditional and informal approaches to healthcare, therefore, have long served the RGV's impoverished populations. These traditions have remained not only due to necessity, desperation, and the region's connection to indigenous and Mexican knowledge systems, but also because of the region's isolation and its Mexican and Tejano homogeneity and cultural continuity. It is important to note that some Tejanos in the RGV have differing or possibly non-existent relationships to *curanderismo* and other informal healthcare practices based on their socioeconomic status and/or migratory ties to other countries and cultures. However, this

report is primarily concerned with the continuation of the historic practice in the region despite constant generational and institutional shifts.

Contrary to white anthropologists studying the folk traditions of the RGV in the 1960s and claiming that *curanderismo* would eventually die out with the cultural, educational, and medical transformations occurring in the rapidly-developing region, Trotter and Chavira argue that "*curanderismo,* like the Mexican culture, continues to exist and resist assimilation because it [satisfies] [the] basic psychological, spiritual, and health needs of the Mexican American community."[56] Thus, *curanderismo* persists, and its healers – particularly among lower and working class Tejanos – remain highly regarded and embraced because of their Mexican folk observances and focus on personalized, accessible, and affordable holistic health. While there are often many risks associated with taking medical advice from uncertified healthcare practitioners, for many in the RGV who have few other options, the risk is worth it.

As we will see later in the oral history, these practices stem partly from necessity, but are also rooted in the comfort, familiarity, and understanding of folk healers who connect to their clients on a personal and cultural level. These medical practices should be examined in biomedical institutional understandings of the RGV, because such practices are "a crucial part of the foundations from which patients derive their attitudes and decisions with respect to biomedical care."[57] The medical community in the RGV would benefit enormously from an examination and understanding of the factors that prohibit community members from trusting biomedical institutions and making use of their services in sustainable ways.[58]

Models for Healthcare

Within the past ten years, a few medical practitioners have joined forces with social scientists and critical race theorists to envision new ways of providing healthcare in the United States – ones that acknowledge and address the ways people of color and the impoverished have historically been marginalized from quality access to healthcare. Their primary concern has been to address the gaps in the American health care system and better understand why the U.S. has the most expensive health care system in the world, yet trails far behind other developed nations by ranking last in access, efficiency, equity, and overall healthy lives.[59] Regardless of the 2010 implementation of the Affordable Care Act, the Commonwealth Fund's publication of the 2015 U.S. scorecard on State Health System Performance, revealed that, in fact, the majority of states in 2014 saw an increase in obesity among minority and low-income adults, with equity gaps based on race and ethnicity worsening in most states in the same time period.[60] As discussed earlier, the RGV operates within an already flawed national healthcare system made worse by the region's poverty, lack of insurance, and historically conflicted relationship to healthcare and the state. Unfortunately, medical professionals are not "trained to consider the [types of] global political-economic structures and local hierarchies that shape the suffering of their patients, [they] are equipped to see only biological and behavioral determinants of sickness."[61]

Students, doctors, and community health providers within the medical establishment are well aware of the ways outside influences and structural barriers inhibit practitioners from providing better care. In a recent survey, 85% of primary care

providers and pediatricians agreed that "unmet social needs are leading directly to worse care for all Americans," voicing concern for the ways they did not feel "confident in their capacity to meet their patients' social needs," ultimately hampering their ability to provide efficient care.[62] There exists major institutional deficiencies – gaps that perpetuate structural violence through the abandonment of state services and affordable care for particular largely impoverished ethnic populations – that both communities and institutional representatives are aware of, yet do not know how to begin approaching because of a lack of training, mentorship, and large constraints on their time, resources, and budget. Weissman et al, in their study of over 2,000 resident physicians concluded that "cross-cultural training [is] a mechanism to address racial and ethnic disparities in health care, but little is known about residents' educational experience in this area."[63] They conclude that in medical training, there are several "barriers to delivering cross-cultural care [that] included lack of time and lack of role models," with an overwhelming amount of resident physicians claiming that there was little clinical time allotted to address cultural issues through formal training.[64]

Scholars and medical doctors have investigated the ways the healthcare system could be improved by means of graduate medical education, with attentiveness to patients in their specific personal, cultural, social, and historical contexts instead of as individuals with isolated issues and diseased body parts in need of quick medical repair. These recent interventions in medical education, policy, and public health serve as models for improving current health disparities in the RGV and acknowledging the region's history, culture, and structural inequities, ultimately painting a more nuanced picture of the real

issues at play in the borderlands. Here, I address cultural competency and structural competency as healthcare models, with examples of the ways they have been implemented in certain schools and public health programs across the United States. This is followed by a brief discussion of competency reception in Texas in particular, and the ways the UT-RGV School of Medicine approaches healthcare and graduate medical education.

Cultural competency is an educational training that is "inclusive of all dimensions of diversity, and has "the ability to move beyond good intentions in cultural relations" as a "lifelong process of acquiring knowledge, attitudes, values, and skills to: understand other cultures along with one's own culture; facilitate understanding among different cultures; confront inconsistencies, biases and unconscious assumptions of these cultures; and take actions to level the playing field."[65] While many have praised examples of cultural competency implementation in medical education on its own, others have criticized the ways it essentializes ethnic and cultural groups and ignores the structural determinants of health, doing little to "address the complex relationships between clinical symptoms and social, political, and economic systems."[66] In response, Jonathan Metzl and Helena Hansen have proposed a graduate medical curriculum that requires training in "structural competency," which they define as "the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases… also represent the downstream implications of a number of upstream decisions about such matters as healthcare and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health."[67] Structural

competency consists of "training in five core competencies: 1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating 'cultural' formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility."[68]

Anthropologist, Medical Doctor, and cultural and structural competency advocate, Seth Holmes, has worked with indigenous migrant communities in Washington and California in dire need of affordable and competent healthcare. His work has been influential in the ways it examines the perceptions that medical professionals have of indigenous migrant patients, revealing the complex issues of bias, power, and lack of resources at hand when providing medical care to migrants – the majority of which are undocumented. Holmes describes how medical providers, regardless of their good intentions and willingness to help, are oftentimes blind to their patients' social and political contexts, which causes them to blame their patients for their health problems.[69] This blindness is caused by medical education that does not train practitioners "to see the social determinants of health problems, or to hear them when communicated by their patients."[70] Instead, medical professionals are given narrow lenses that "decontextualize sickness, transporting it from the realm of politics, power, and inequality to the realm of the individual body."[71] Implementing new educational guidelines and modes of perception would encourage a reduction in the ways the biomedical institutional gaze has blamed the RGV and its people for their illnesses. Further, it would support the long-term health of communities in dire need. Unfortunately, the state of Texas, which has cut

social services in the past several years, and even opted out of the ObamaCare Medicaid expansion in 2015, has done little to address the issues facing their poorest residents.[72]

In March of 2013, for example, Senator Eddie Lucio, who presides over substantial portions of the Rio Grande Valley – Cameron, Hidalgo, Willacy counties, and others – introduced to the senate bill SB 1346. Its stipulations called for the establishment of a task force on cultural competence, which would make recommendations on the implementation of cultural competence health education curricula in Texas higher education, which was to include:

> knowledge of cultural awareness and competence in their respective health field, including: cross-cultural communication, culturally and linguistically appropriate health policy considerations, exploration of health beliefs and explanatory models, culturally competent health care delivery, and culturally and linguistically competent care supported by policy, administration, and practice.[73]

SB 1346 died in committee hearings and currently stands as being "referred to Higher Education" as of March 2013. Currently, the upcoming UT-RGV School of Medicine – a public educational institution without any state regulations or funding toward the incorporation of cultural competency – claims that its graduate medical education will be "characterized by a competency-based curriculum," that prioritizes "improving health at the individual and community level."[74] They plan to graduate physicians who will be: "patient advocates, community focused, culturally aware, collaborative leaders, life-long learners, and problem solvers."[75] While the UT-RGV medical school may address many of the real medical needs of the community, it will be doing so on a mere surface level that is either not supported or required by the state of Texas, or in ways that require outside intervention and funding from private or federal

agencies and non-profit organizations that either seek to address or profit from the region's needs. Something that further complicates the power dynamics of the institution in relation to the community is that while the medical school's graduates will be required to complete their residency in the RGV, four out of the six available residency programs are available through university partnerships with the physician-owned, for-profit, Doctor's Hospital at Renaissance, which has a reputation for "aggressively recruiting high-volume physicians to become investors and send patients there,… giving [them] an unholy temptation to over order [tests, surgery, or other care]."[76]

In order to effectively serve the community, the institution and the region's community outreach programs must implement a thorough educational system of checks and balances that continually call for deeper understandings of the region's healthcare models and belief systems. However, as of now, the University has only described its curriculum interests in competency as being primarily concerned with meeting the "Institutional Requirements established by the Accreditation Council for Graduate Medical Education (ACGME)," which revolves around six central competencies; 1) Patient Care; 2) Medical Knowledge; 3) Practice Based Learning and Improvement; 4) Systems Based Practice; 5) Professionalism; 6) Interpersonal Skills and Communication.[77] Professionalism describes the ways residents are expected to "demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities and sexual orientation."[78] Interpersonal Skills and Communication describes the expectation that

residents "communicate effectively with patients, family, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds."[79]

Under ACGME requirements, there is a Clinical Learning Environment Review (CLER), which defines a review of "Excellence" as the thorough training of residents, fellows, and faculty members for receiving training in cultural competency relevant to the patient population served by the clinical site.[80] There is little to no description of the ways students are evaluated in relation to their patient populations and the ways they are held to cultural competency standards on a daily basis. However, from these educational methods, requirements, and evaluations, it becomes evident that the institution is (at least formally) paying attention to the education and service of medical students in comparison to its relevancy and effectiveness with the particular patient populations of the regions served. Upholding these competencies requires the student to effectively "demonstrate sensitivity and responsiveness" and "communicate effectively with patients…as appropriate across a broad range of socioeconomic and cultural backgrounds." How are sensitivity, communication, and responsiveness measured as they relate to different patient populations? What does the assessment of cultural competency look like? There are not very clear answers to these questions and oftentimes, in training, these are models that are discussed but not implemented, practiced, or tested and evaluated harshly because of the difficulty of determining cultural satisfaction with healthcare. As stated earlier, resident physicians and medical practitioners seem keenly aware of the fact that their knowledge and training in such cases falls short, but often feel that their hands are tied or they do not have the time and training to carry out better practices.

As a solution to these ambiguous methods of evaluation, Wendy Miller and Karen D'Angelo at the University of Connecticut have provided a unique cultural competency curriculum model that offers milestone data and addresses more concrete expectations of CLER (Clinical Learning Environment Review). In their research, they addressed how 25% of resident physicians self-reported that they were "not prepared to provide care for patients with beliefs at odds with Western medicine," another 25% were "not prepared to provide care for new immigrants," and 24% lacked the skills to identify relevant cultural customs that impact medical care.[81] Their curriculum, which they offer as a solution, has begun the cross-cultural training of medical students in association with the Hispanic Health Council. It includes online learning modules that require a passing score of over 80%, a four-hour cross-cultural and diversity inclusiveness training in partnership with the Hispanic Health Council of Hartford, and an assessment of clinical skills. They have provided a model that is inclusive, thorough, and even provides the potential costs to universities who seek to implement it – less than $260 per year, per resident.

Their work seeks to:

> provide a clear definition of cultural competence, identify racial and ethnic health disparities and the importance of cultural competence in eliminating these disparities, and to describe the impact of social determinants of health on health inequities, patient health status, and healthcare adherence, to describe the Hartford region as an example of socio-economic contrasts and how they are reflected in health inequities, recognize the pervasive and negative impact that attitudes such as stereotyping and blaming the victim generate, assess and debunk personal stereotypes and biases, describe how to work effectively with an interpreter, and demonstrate assertive communication and cultural brokering skills and identify how they contribute to patient-centered care.[82]

Interdisciplinary medical scholarship emerging from a current and particular sociohistorical moment in the United States has scholars and medical practitioners placing narratives of marginalization, institutional, and structural racism, in conversation with the nation's history and the current inequities inherent in the nation's healthcare system. Years after The Patient Protection and Affordable Care Act (PPACA) was signed into law, many people who previously did not have health insurance are now covered. However, there are still countless problems inherent in the American healthcare system resulting from larger structural and political issues. Our nation's neoliberal policies increasingly privatize the medical and pharmaceutical sectors in the U.S., which increase co-pays, lower insurance plan coverage rates, and profit enormously from the sick, the helpless, and the indigent who either are misunderstood in the clinic or avoid the clinic altogether until a medical issue is much worse and can no longer be ignored. The sick and indigent, in a terrible cycle of oppression and necessity, are in such situations because they are participants in a system that uses their bodies for labor, chews them up, and spits them out. My analysis concurs with researchers who have considerably advocated for cultural and structural competency in medical education and training, and who call for a reevaluation of the American medical system that currently directly and indirectly perpetuates what Holmes cites as "the embodiment of a different expression of the violence continuum" – violence that turns a blind eye to the real physical needs of its population and enables them to seek out other options on their own.[83]

"What Had Always Worked for Us": Healthcare Narratives in the RGV

To map out some of the dangers that arise when divergent healthcare understandings clash in the RGV, I analyze the oral history of RGV-local Elva Guzman. Her narratives emphasize the communal and regional historical significance of *curanderismo,* substantiating the need for the medical and historical recognition of the practice in an institutional setting. While singular, Elva Guzman's oral history provides evidence of the ways *curanderismo* has shaped regional understandings of health and community in distinct ways, while mapping out the problems that can arise when health care practitioners operate without cultural sensitivity or competency training. Her personal accounts pull from community knowledge and generational memories to piece together a Tejana worldview and use oral history "not only [as] a tool or method for recovering history; [but] also [as] a theory of history which maintains that the common folk and the dispossessed have a history and that this history must be written."[84] Further, by reckoning with the types of disdainful relationships she describes in relationship to biomedical institutions, I engage in "vernacular history-making practices" that recuperate local stories of systemic violence along the border.[85] I argue that histories like hers must be written and should account for the public and private institutions continue to expand into the area, forging problematic and insensitive relations with the locals in the communities they serve.

Although I have no reason to doubt the validity of Guzman's accounts, which are primarily from her own memories of growing up in the RGV, Américo Paredes reminds me that, as an ethnographer, albeit a native one, researchers should "always be aware of

the informant as a potential performer of folklore."[86] While limiting my analysis to the history and narratives of one woman comes with its own set of representative issues and offers only a narrow local perspective, like oral historian Gary Okihiro, I envision oral history as a "tool for recovering history [and forging] a link between the academy through ethnographic field techniques" understanding that ultimately, "it has a potential for raising social consciousness and [providing] strategies for social change."[87] Guzman's narrative advocates for social change in relation to the proposed medical school's community relations and, arguably further, in relation to larger biomedical institutional values and the state structural violence of public health and human rights violations along the border. Recording and privileging her history place her experiences in conversation with the region's future, and also create a small archive of folk medicine and community relations in the region. In the following excerpts from our many conversations, I ask Guzman about her first experiences in biomedical institutions, what *curanderismo* means (and/or has meant) to her and her community, what the healer symbolizes, and how the healer is usually understood.

Elva Guzman is a stout, tenacious seventy-year-old woman who was born and raised in the rural agricultural communities surrounding Edinburg, Texas in 1945. She interchangeably self-identifies as Tejana, Mexicana, or Mexican, even though she has always been a proud U.S. citizen, which, notably, distinguishes her from many of the disenfranchised undocumented RGV residents mentioned previously in this report, who are more directly impacted by the lack of accessible care in the region. The eldest of six children, Guzman took on many domestic and agricultural responsibilities at a young age,

often working in the fields alongside her parents and helping her mother provide healthcare for her younger siblings on their small ranch far from the center of town. Although Guzman herself does not identify as a practicing *curandera,* her vast botanical knowledge of the region's plant life and herbal remedies is deeply rooted in the local *curandera/o* tradition. Just like the countless Tejanas/os on the southernmost end of the Texas-Mexican border, Guzman is fluent in English and Spanish, but prefers to speak in what RGV-native Gloria Anzaldúa considers the Tex-Mex or Spanglish "border tongue" – marked by switching deftly between the two languages in a single sentence.[88] Talking to Guzman is easy. She loves history and storytelling and can provide an anecdote about almost every corner of Hidalgo County. Every time we speak in person, her nails are well manicured, her hair molded into a voluminous bob, lipstick perfectly intact; however, she regularly reminds me that things were not always this way:

> *Pos (well),* I was born in the mid-forties around Edinburg *allá en un ranchito* (over there on a little ranch) pretty far from town. In those days everybody had their own little gardens and crops on their land and grew their own *hierbitas pa' esto o'l otro* (herbs for this and that). Even though there were hospitals and doctors in neighboring cities, *pos* we didn't have any money or cars to go see them *pa' cada cosilla* (for every little thing). I never even stepped foot in [a doctor's office] until I got married in 1964. I remember Agustin had been working on the lawn and gashed open his hand, *pero gacho* (slang for intense/brutal). Well I did what my mother always taught me and cleaned the wound with alcohol and then grabbed a *telaraña* (spider web) and placed it over the wound to stop the bleeding. It worked like a charm as always but when we started realizing how deep the gash was, our neighbor said, "no, you have to take him for stitches."
>
> I had never been to a doctor or any hospital so you can imagine I was nervous. When we went in to see the doctor, he took a look at the cut and asked how we had treated it. When I told him I had patched [the wound] up with spider webs, *nombre,* he threw a fit, talking to us about the germs and dust that could have infected his hand. *Pos qué sabía el Mexicano de "*germs" *en el rancho*? (Growing up on a ranch, what did

> Mexicans know about germs?) We never worried about bacteria and all that; we just knew what had always worked for us.[89]

Guzman's awareness of the conflicts between traditional and modern medicine stemmed from negative experiences in biomedical institutions. These experiences degraded her, made her feel unwelcome and scrutinized in the white sanitized world of biomedical healthcare, ultimately prompting her to keep her beliefs in folk healing and her use of household remedies to herself. Holmes would describe this kind of alienation as one of the ways "the victim of… economic and historical inequalities is blamed for her predicament… even though these are the outcomes of social structures by which she is situated."[90] While Guzman now interacts with medical professionals on a regular basis because of her diabetes, she remains suspicious of white doctors in the area, who she feels make a living off the exploitation of insurance companies and common folks for profit.[91] It is important to note that for Guzman, the conflicts between biomedicine and folk healing do not emerge from traditional healers criticizing biomedicine. *Curanderas/os* are known for being accepting of modern practices and treatments and for the most part, encouraging patients to follow their doctor's orders. They do not see themselves as opposing evidence of biomedical illness; in many cases they simply offer alternative practices for supplementing biomedical healing with herbal and spiritual influences.

Guzman's past experiences and current fears reveal some of the biomedical stigmas stemming from racialization and class-bound notions of traditional folk healing methods in an increasingly urban Rio Grande Valley. The immense cultural divide between Guzman and the doctor emerges when the doctor sneers at the natural remedies

used to heal Guzman's husband, exemplifying the cultural dissonance between biomedical institutions and the natural healing practices that Guzman claims "had always worked for us."[92] Until recently, conversations about folk medicine and its acceptance and understanding at the institutional level have been scarce, ultimately bringing me to question whether certain doctors are suited for practicing in specific ethnic communities where the cultural contexts of illness are not to be taken lightly or brushed off as incorrect and problematic. UT-RGV's School of Medicine cannot operate in the region and engage in the kind of community-based outreach it claims to prioritize if its practitioners and *promotoras* "[throw] a fit" each time their patients report household treatments. This kind of relationship breeds hostility, distrust, and may ultimately push the patient away from biomedical institutions in the future when an ailment may need to be taken seriously.

The region's traditional and informal healthcare practices do not have to be taken up and actively practiced by health care providers, but merely considered a serious and influential component of RGV Tejano livelihood, culture, and worldviews. In the following excerpt, Guzman's social and historical understanding of *curanderismo* serves as a potential model for effective health care that is respectful of traditional medicine and centers around culturally and structurally competent care that understands the patient and their community. *Curanderismo's* healers continuously serve as critical community authorities on healthcare and tradition in the RGV. Guzman brings home the sense that Tejanos in the valley have intimate community connections to *curanderismo* and its local healers – connections that the biomedical system should neither ignore nor debase.

Though several months had gone by since my last in-person conversation with Guzman, she advised me to call her if I ever wanted another history lesson, "*o si necesitas una oración o lo que sea*" (if you need me to pray for you or whatever it may be). Guzman takes her storytelling seriously, particularly when it has to do with *curanderismo* in the valley, because she feels its dynamics are changing and its long history is slipping away. Instead of answering my questions quickly, Guzman takes the task earnestly, making me wait, taking her time to relax, prepare, and make sure we converse on speakerphone over a cup of coffee – as if I were sitting alongside her in the comfort of her living room. She considers herself a history buff and cares deeply about the valley's "regional folk culture:" a culture where members are "wedded to the land and the land holds memories. The people themselves possess identity and ancestry through continuous occupation of the same soil."[93]

I respect Guzman's voice and her willingness to share her personal experiences and think about them in relation to the region's rapidly approaching urban future. Her thorough response narrates a Tejana worldview, through which she outlines historical and popular significance of *curanderismo* in South Texas. More importantly, it provides a positive model for the kind of successful community-based collaborations possible when healthcare providers truly understand and collaborate with their patients holistically:

> *Pues* (Well)*,* mostly I see [the *curandera*] as showing resourcefulness and wisdom. They have wisdom from our culture that sometimes comes down to a matter of survival – stuff that's been, you know, passed down from mothers, *tías* (aunts), grandmothers, *vecinas* (female neighbors), *comadres*,[94] *tu sabes* (female friends, you know) – but also they have these extra senses that are just gifts from God. They are a very important part of the community, especially the poor community – *los ranchos, los barrios, las colonias, pa' los que no tienen papeles* (on

ranches, in lower/working class neighborhoods, in poor rural settlements, for the undocumented). Back then they were always available to you. Now that's a little bit different, *pero* (but) I have this feeling that they know how much they are needed around here.

They offer help outside of official establishments. And they're someone you can trust. I mean these women tended to people personally. It was much better to go to someone who understood you. *No, no, no, como antes, cuando me ayudaba Doña Conchita,* my midwife, *ella venía y daba la vuelta todos los días.* (No, no, no, like before, when my midwife, Doña Conchita, would help me, she would come around everyday). They do that to make sure people are okay, to double check and help them. *Y no venían a cobrarte, venían a ayudarte.* (And they didn't come to charge you, they came to help you). *Tú les dabas lo que tú querías.* (You would pay them whatever you could pay them). *Ésa Doña Conchita,* (that Doña Conchita), she would really help the neighborhood. I mean everyone in the neighborhood knew about her. It was all by word of mouth and she was always ready to go. *Te curaba de empacho, susto, ojo,*[95] *te sobaba,* (She would cure you of indigestion, emotional trauma, the evil eye, massage you) whatever, but mostly she was a *partera* (midwife). You gave her whatever you wanted, a few dollars here and there. *Ella sabía,* (She knew) they were there to serve people – it was out of love and care. They were there to help people that could not afford to go to the doctor and hospital.

In a way these people are important sources of knowledge – about culture, about health, about wellbeing, about diet. These healers kind of show you what's possible and also the expectations. As a woman, what you should know about the body, the land, plants, certain household remedies, and community connections. They have that cultural knowledge, like true traditions, you know? It only comes from experience and wisdom.

Y ahora, pos sí, los doctores te arreglan, claro, con chingos de pastillas (And sure, now doctors can fix you with loads of pills) – and they charge an arm and a leg. *Y con ellas no*, *todo natural con remedios, tesitos, oraciones* (However, *curanderas* would do everything naturally, with remedies, teas, and prayer) – how people have been doing it for centuries. And they know when they can't help you, when you need certain surgeries, tests or medicine that only a doctor can do.

Guzman's discussion of the personalized care provided by *curanderas/os* offers a framework for successful community health intervention – a means of understanding a healthcare model that makes her and others like her feel comfortable – one that is

culturally competent, based in regional tradition, and collaborative. By depicting *curanderismo* as a practice whose local healers are 1) powerful, trustworthy community figures, 2) modes of cultural transmission and preservation, and 3) symbols of resourcefulness, health, and survival outside dominant institutions and ideologies, Guzman advances a narrative replete with possibility and promise for future healthcare practitioners in the valley – one that can undoubtedly become integrated in cultural and structural competence medical education models – while also depicting the practice's historical and social significance.

Despite the fact that I asked Guzman about *curanderas/os*, it is striking that she limits her conversation strictly to female healers and repeatedly discusses womanhood and the importance of female communities in relation to healing. Guzman situates healing as a crucial part of the region's gendered expectations for women of her generation, one passed down from "mothers, tías, grandmothers, vecinas, comadres," but in some cases, as a specific "gift" that God only grants to certain women.[96] By privileging female cultural knowledge and *curanderas,* she demonstrates her understanding of the healers in the Texas-Mexican borderlands: powerful community figures that expand the possibilities and expectations of womanhood. Her anecdote about *Doña Conchita* offers an incredible example of the healer as a strong community leader – a person that understands, can be trusted, and offers a connection to Mexican cultural heritage.

Her example of *Doña Conchita's* feminized community knowledge and care becomes part of a continuing regional legacy of self-sufficiency, especially when

considering the severe cuts to women's health and reproductive clinics and funding in the RGV that are currently pressuring the women of the region to acquire their family planning resources outside clinical settings – with midwives and community health workers, or through natural remedies or drugs purchased across the border. The healing power of community knowledge, education, and support systems that she discusses as part of the region's history still exists in the voices and the recent mobilization of the Nuestro Texas women mentioned previously, who continue to shed light on the gaps in equitable healthcare resources in the U.S. borderlands. These women, like the *curanderas* and self-sufficient Tejanas before them, have found ways to rally local support for one another, and have recently gone even further, calling national and international attention to their plight as part of a longer legacy of state violence and human rights violations in the borderlands.

These women, both then and now, are keepers of tradition and cultural knowledge. They are wise women who have been forced to reckon with a multiplicity of regional knowledges concerning resources, culture, health, the body, diet, plants and herbs, the land, their community.[97] The *curanderas* Guzman describes, in this instance, are practitioners of tradition, cultural transmission and preservation – women who labor out of love and genuine care for their willfully ignored Tejano communities along the border. According to Guzman's account, they do so unselfishly, and with a full understanding of their own limitations, describing when a certain ailment is out of their hands and must be taken care of by a physician. Further, women's interactions with *curanderas* provide a unique open and empowering space for community connections

and cultural preservation. Similar to Lourdes Gutierrez Najera's understanding of Yalalteco migrant women in "Hayándose: Zapotec Migrant Expressions of Membership and Belonging," this communal interaction creates a gendered space of belonging that contributes to cultural continuity. While the financial exchanges described by Guzman are minimal ("a few dollars here and there"), they nonetheless contribute to a sense of community "by fostering economic and emotional interdependence between the women," offering insight into "the ways that women build on networks to create spaces of belonging."[98] *Curanderismo* is a bastion of tradition and cultural heritage, which medical practitioners would do well in observing.

While many practitioners of *curanderismo* are not women (in fact, some of the RGV's most famous healers were men)[99], the gendered spaces of belonging that Guzman discusses must be noted. They are arenas where women – as clients and healers – "participate in cultural practices and lay claim to ethnic and cultural memberships to combat vulnerability, depravation, and domination."[100] By "offering help outside of official establishments" and working with people in "*los ranchos, los barrios, las colonias, [y con] los que no tienen papeles*" they resist the dominant culture and exist outside of the formal economy.[101] This informality and self-sufficiency is a fundamental part of the region's historical relationship to the state – one of marginalization and state-sanctioned structural violence – yet also one centered around notions of independence, sovereignty, and community support in the face of a severe regional disparities.

Instead of turning to doctors who overcharge for "*chingos de pastillas,*" the *curanderas* of her generation offered all natural remedies sourced from local agriculture

and household items. Guzman understands ideal healers as powerful sources of local knowledge that embrace their communities, understand their marginalization, and work toward that community's health and survival. If the future medical school's community-based healthcare providers can relate to the population through language, why not also through ethnic and cultural promotion, belonging, and understanding through cultural and structural competency models?

My conversations with Guzman provide a unique, albeit narrow, lens for understanding *curanderismo* in the Rio Grande Valley, a borderland region where traditional healers offer resources that biomedical institutions historically have not. By turning to community members first, I illustrate the "valuable sources in [Guzman's] own cultural community" and highlight the ways in which "everyone has the capacity to be a critical cultural reader."[102] Guzman's account, while only reflecting the gendered and classed experience of one woman, offers a unique contribution to "the long history and diversity of working-class Latino experiences."[103] My exploration of *curanderas* as regional figures that successfully offer personalized, holistic care looks inwardly at community healthcare histories to facilitate a model for future intervention. Guzman's oral history is an alternative archive that allows readers to peer intimately into the region's traditions and needs, enabling a "recover[y] and rethink[ing] [of] community histories and memories;…[and] highlight[ing] the creative activism and cultural production emerging from various Latina/o populations," while also recording community-based understandings of health as models for the future operation of community-based healthcare.[104]

By describing these community healers as people you could trust, people who "tended to you personally" and who were there not to charge you, but to serve you, Guzman gets at some of the personalized advantages unique to *curanderismo* – advantages which perhaps may not always be available to the rural poor in biomedical institutions that treat them impersonally, charge "an arm and a leg," and make no attempts to understand patients holistically. In Elizabeth de la Portilla's *They All Want Magic: Curanderas and Folk Healing* (2009), she argues that "the healer essentially 'belongs' to the community; they have a public persona that outweighs their private lives. How they conduct themselves and how they operate are dictated by tradition."[105] *Curanderas/os* in the Rio Grande Valley go beyond physical treatment, using spirituality and tradition to "satisf[y] their patient's need for meaningfulness and connectedness… thereby activating symbolically induced healing through the power of suggestion or faith or belief."[106] Thus, it becomes plain to see why, for Guzman and others in the community, "it was much better to go to someone who understood you." My hopes are that one day, biomedical institutions for all patients may be places that offer not only healthcare and resources, but compassion that makes patients feel safe, understood, and physically and spiritually whole.

My interview with Guzman reveals the importance and value Tejanos place on *curanderismo's* patient-centered, personalized health care and the possibilities inherent in its community-based empowerment. Her interactions with *Doña Conchita* created a productive and convivial space of belonging and marginalization, and, in medical terminology today, can be described as exhibiting high levels of provider cultural

sensitivity and interpersonal control. I contend that the positive qualities Guzman attributes to *curanderismo* can and should be implemented in the training and development of the region's medical school affiliates, particularly in their methods for handling community outreach and its medical school curriculum. When a patient is placing their life in the hands of health care practitioners, empathy and cultural and structural competency are necessary.

Conclusion

This M.A. paper focuses on the RGV, its regional identity, and its dire health needs and unique recent medical development. Further, it highlights the need for new lenses through which to view healthcare and the body, encouraging scholars, medical practitioners, and institutions to consider the ways health disparities, stigmas, and ethnic and cultural conflicts "need to be understood as the sequellae of a host of financial, legal, governmental, and ultimately ethical decisions with which medicine must engage politically if it wishes to help its patients clinically."[107] Concluding with Guzman's oral history offers a more nuanced understanding of the Tejanos in the RGV, their beliefs, their culture, and further, provides an example of the kinds of institutional distrust common among the region's impoverished and aging population. While she serves as merely one example of these kinds of interactions, I felt that the depth and honesty of our conversations provided the sociohistorical context necessary to understand her both as a person and a patient, in both cultural and structural ways. Limiting my discussion of oral history to one woman's experiences is one of my report's limitations, which further highlights the need for further research and regional, bi-national oral history collection.

My intention here has been to offer an awareness of healthcare disparities in the RGV and call for better, more compassionate care in the region. However, I am aware that the issue is much deeper, and that the history of ethnic and racial projects along the Texas-Mexico border has deeply shaped the region and the identity of its inhabitants. Thus, merely "demanding more public health resources would not address the demeaning dimension of border health encounters."[108] This kind of appeal would neglect the

stratified structures in which border inhabitants live, work, and make sense of themselves, their bodies, and their communities. Instead, by offering an analysis of regional identity and self-sufficient modes of treatment in the face of disparity, I reckoned with a longer history that has placed poor and working class borderlands residents at the bottom of an already stratified and broken privatized healthcare system in the United States. Such understandings must be incorporated into graduate medical education if we are to effectively meet the needs of the region and promote long-term wellness and holistic, humanistic modes of patient understanding. Large strides in cultural and structural competency are already being made in medical education and can easily be implemented in a region that would benefit enormously from its approaches to healthcare in low-income communities.

One way to begin the process of understanding and compassion in the region is for institutions and community health providers to connect with patients and locals on a personal level, devoting time and effort to understanding their structural and cultural positionality and worldviews. This can be done through graduate medical education that prioritizes the collection of community oral histories, as well as promotes meaningful resident-patient interactions. Guzman's oral history is an example of the fruitful cultural and historical understandings that can emerge from such conversations and interactions. The incorporation of narratives like Guzman's into graduate education would serve the region's health practitioners immensely, enabling better communication, trust, and preventative measures. Overall, this would cut extreme medical expenses that pile up when a patient continues to avoid biomedical institutions because of the cost or the

anxiety and fear it causes them, ultimately worsening an otherwise preventable illness. Currently, the American healthcare system struggles with time constraints, insurance constraints, and educational medical norms that inhibit practitioners from seeing structural determinants of illness. Regardless of whether improvements are slowly made in these arenas with the continual years of the Affordable Care Act, *curanderismo* and informal approaches to healthcare will persist in the impoverished RGV, as they always have. It is our duty to attempt to understand the ways these healthcare approaches can live together in a balanced way.

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Notes

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[23] Ibid., 8.
[24] Ibid., 79.
[25] Ibid., 5, as well as Chapter 2.
[26] Valerio-Jiménez, *River of Hope,* 234.
[27] While outside the scope of my research here, it must be acknowledged that long standing Central American and Caribbean populations in Texas problematize the framework provided here and should be acknowledged in future research.

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